FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032029

Facility Name: HICKORY NURSING PAVILION

Address: 9246 SOUTH ROBERTS ROAD (Number) HICKORY HILLS (City) 60457 (Zip Code)

County: COOK

Telephone Number: (708) 598-4040 **Fax #** (708) 598-3796

IDPA ID Number: 363499382001

Date of Initial License for Current Owners: 03/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) RICHARD S. SGARLATA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	34	Skilled (SNF)	34	12,410	1
2		Skilled Pediatric (SNF/PED)			2
3	40	Intermediate (ICF)	40	14,600	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,209	69	968	8,246	8
9	SNF/PED					9
10	ICF	12,328	424		12,752	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,537	493	968	20,998	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.74%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/1/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 968

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	103,537	29,142	5,904	138,583		138,583		138,583			1
2	Food Purchase		97,157		97,157	(21,966)	75,191	(23)	75,169			2
3	Housekeeping	79,944	31,745		111,689		111,689		111,689			3
4	Laundry	30,728	10,514		41,242		41,242		41,242			4
5	Heat and Other Utilities			45,516	45,516		45,516	947	46,463			5
6	Maintenance	14,108	14,742	54,626	83,476		83,476	(6,361)	77,115			6
7	Other (specify):*							1,122	1,122			7
8	TOTAL General Services	228,317	183,300	106,046	517,663	(21,966)	495,697	(4,315)	491,383			8
	B. Health Care and Programs											
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	673,914	22,282	12,197	708,393		708,393	(420)	707,973			10
10a	Therapy	39,568		6,429	45,997		45,997		45,997			10a
11	Activities	29,667	895	2,252	32,814		32,814		32,814			11
12	Social Services	32,013	187	1,095	33,295		33,295		33,295			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	775,162	23,364	23,773	822,299		822,299	(420)	821,879			16
	C. General Administration											
17	Administrative	59,140		145,255	204,395		204,395	(46,858)	157,537			17
18	Directors Fees											18
19	Professional Services			25,172	25,172	(2,160)	23,012	746	23,758			19
20	Dues, Fees, Subscriptions & Promotions			21,784	21,784		21,784	(9,553)	12,231			20
21	Clerical & General Office Expenses	4,763	31,889	48,838	85,490		85,490	(25,659)	59,831			21
22	Employee Benefits & Payroll Taxes			160,290	160,290	21,966	182,256		182,256			22
23	Inservice Training & Education											23
24	Travel and Seminar			974	974		974	236	1,210			24
25	Other Admin. Staff Transportation			619	619		619	1,639	2,258			25
26	Insurance-Prop.Liab.Malpractice			37,754	37,754		37,754	908	38,662			26
27	Other (specify):*							8,090	8,090			27
28	TOTAL General Administration	63,903	31,889	440,686	536,478	19,806	556,284	(70,451)	485,833			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,067,382	238,553	570,505	1,876,440	(2,160)	1,874,280	(75,186)	1,799,094			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HICKORY NURSING PAVILION #0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			29,886	29,886		29,886	65,144	95,030			30
31	Amortization of Pre-Op. & Org.							1,275	1,275			31
32	Interest			3,918	3,918		3,918	64,837	68,755			32
33	Real Estate Taxes			94,653	94,653	2,160	96,813		96,813			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(174,571)	5,429			34
35	Rent-Equipment & Vehicles			236	236		236	3,343	3,579			35
36	Other (specify):*											36
37	TOTAL Ownership			308,693	308,693	2,160	310,853	(39,972)	270,881			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,274	53,340	78,614		78,614		78,614			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		25,274	93,855	119,129		119,129		119,129			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,067,382	263,827	973,053	2,304,262		2,304,262	(115,158)	2,189,104			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	29,700	30		9
10	Interest and Other Investment Income	(3,501)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(23)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(526)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,674)	21		24
25	Fund Raising, Advertising and Promotional	(923)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,028)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,891)	20		28
29	Other-Attach Schedule	(21,177)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (39,043)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(76,115)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (76,115)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (115,158)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

HICKORY NURSING PAVILION

ID# 0032029

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous income	$ (6,754)	21	1
2	Illinois Council COPE	(1,804)	20	2
3	Capitalized R&M	(9,603)	06	3
4	Building co. Illinois replacement tax	(81)	21	4
5	Legal invoice 12/01	63	19	5
6	Out of c/r period legal fees	(321)	19	6
7	Capitalized R&M	(2,679)	06	7
8				8
9				9
10				10
11				11
12				12
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90				90
91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(23)											(23)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			947									947	5
6	Maintenance	(12,280)		657	5,262								(6,361)	6
7	Other (specify):*				1,122								1,122	7
8	**TOTAL General Services**	(12,303)		1,604	6,384								(4,315)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(420)									(420)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**			(420)									(420)	16
	C. General Administration													
17	Administrative			(134,204)	87,346								(46,858)	17
18	Directors Fees													18
19	Professional Services	(258)		1,004									746	19
20	Fees, Subscriptions & Promotions	(9,618)		65									(9,553)	20
21	Clerical & General Office Expenses	(43,063)	81	17,323									(25,659)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			236									236	24
25	Other Admin. Staff Transportation			1,639									1,639	25
26	Insurance-Prop.Liab.Malpractice			908									908	26
27	Other (specify):*			3,196	4,894								8,090	27
28	**TOTAL General Administration**	(52,939)	81	(109,833)	92,240								(70,451)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(65,242)	81	(108,649)	98,624								(75,186)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	29,700	35,397	47									65,144	30
31	Amortization of Pre-Op. & Org.		1,275										1,275	31
32	Interest	(3,501)	68,338										64,837	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(180,000)	5,429									(174,571)	34
35	Rent-Equipment & Vehicles			3,343									3,343	35
36	Other (specify):*													36
37	TOTAL Ownership	26,199	(74,990)	8,819									(39,972)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(39,043)	(74,909)	(99,830)	98,624								(115,158)	45

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached		See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental income	$ 180,000	Hickory Healthcare Association		$	$ (180,000)	1
2	V	32	Interest income	862	Hickory Healthcare Association			(862)	2
3	V	32	Mortgage interest		Hickory Healthcare Association		69,200	69,200	3
4	V	30	Depreciation		Hickory Healthcare Association		35,397	35,397	4
5	V	31	Amortization		Hickory Healthcare Association		1,275	1,275	5
6	V	21	IL. RT		Hickory Healthcare Association		81	81	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 180,862			$ 105,953	$ * (74,909)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	STAY CARE MANAGEMENT, LTD.	100.00%	$ 947	$ 947	15
16	V	6	REPAIRS AND MAINT.				657	657	16
17	V	10	REHABILITATION CONS.				(420)	(420)	17
18	V	17	ADMIN. SAL.-NON OWNER				11,051	11,051	18
19	V	19	PROFESSIONAL FEES				1,004	1,004	19
20	V	20	DUES, SUBSCRIPTIONS				65	65	20
21	V	21	CLERICAL & GENERAL				17,323	17,323	21
22	V	24	SEMINARS				236	236	22
23	V	25	ADMIN. STAFF TRAVEL				1,639	1,639	23
24	V	26	INSURANCE				908	908	24
25	V	27	EMPLOYEE BENEFITS				3,196	3,196	25
26	V	30	DEPRECIATION				47	47	26
27	V	34	BUILDING RENT				5,429	5,429	27
28	V	35	EQUIPMENT RENTAL				3,343	3,343	28
29	V								29
30	V	17	Management fees	145,255				(145,255)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 145,255			$ 45,425	$ * (99,830)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIET. COMP - S. WEBSTER	$	STAY CARE MANAGEMENT, LTD.	100.00%	$	$	15
16	V	6	MAINT. COMP. - NON-OWNER				5,262	5,262	16
17	V	7	EMP. BEN. - S. WEBSTER						17
18	V	7	EMP. BEN. - MAINT. NON-OWNER				1,122	1,122	18
19	V	17	ADMIN. COMP - H. WENGROW				71,635	71,635	19
20	V	17	ADMIN. COMP - J. WEBSTER				15,711	15,711	20
21	V	27	EMP. BEN. - H. WENGROW				4,060	4,060	21
22	V	27	EMP. BEN. - J. WEBSTER				834	834	22
23	V	30	DEPR.- AUTO - MINI VAN						23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 98,624	$ * 98,624	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Howard Wengrow	Owner	Administration	14.19%	See attached	20	30.70%	Salary-Staycar	$ 71,635	17-7	1
2	Jeff Webster	Owner	Administration	14.19%	See attached	4	6.10%	Salary-Staycare	15,711	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 87,346		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: STAY CARE MANAGEMENT, LTD.
Street Address: 7313 N. WESTERN AVE.
City / State / Zip Code: CHICAGO, IL. 60645
Phone Number: (773) 338-2121
Fax Number: (773) 338-2286

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	172,882	5	$ 7,800	$	20,998	$ 947	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	172,882	5	5,412		20,998	657	2
3	10	REHABILITATION CONS.	PATIENT DAYS	172,882	5	(3,462)		20,998	(420)	3
4	17	ADMIN. SAL.-NON OWNER	PATIENT DAYS	172,882	5	90,986	90,986	20,998	11,051	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	172,882	5	8,268		20,998	1,004	5
6	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	172,882	5	534		20,998	65	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	172,882	5	142,626	102,270	20,998	17,323	7
8	24	SEMINARS	PATIENT DAYS	172,882	5	1,940		20,998	236	8
9	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	172,882	5	13,498		20,998	1,639	9
10	26	INSURANCE	PATIENT DAYS	172,882	5	7,475		20,998	908	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	172,882	5	26,316		20,998	3,196	11
12	30	DEPRECIATION	PATIENT DAYS	172,882	5	391		20,998	47	12
13	34	BUILDING RENT	PATIENT DAYS	172,882	5	44,700		20,998	5,429	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	172,882	5	27,521		20,998	3,343	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 374,005	$ 193,257		$ 45,425	25

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: STAY CARE MANAGEMENT, LTD.
Street Address: 7313 N. WESTERN AVE.
City / State / Zip Code: CHICAGO, IL. 60645
Phone Number: (773) 338-2121
Fax Number: (773) 338-2286

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	35	1	11,983	11,983			1
2	6	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	5	26,310	26,310	8	5,262	2
3	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	35	1	1,188				3
4	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	5	5,610		8	1,122	4
5	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	5	232,813	232,813	20	71,635	5
6	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	65	5	255,296	255,296	4	15,711	6
7	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	5	13,197		20	4,060	7
8	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	65	5	13,554		4	834	8
9	30	DEPR.- AUTO - MINI VAN	AVG. HOURS WORKED	35	1	1,775				9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 561,726	$ 526,402		$ 98,624	25

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Hickory Healthcare Assoc.	X		Mortgage			$	$ 922,898			$ 69,200	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 922,898			$ 69,200	9
	B. Non-Facility Related*											
10	See Supplemental Schedule							58,277				10
11	Interest expense										3,917	11
12	Interest income										(3,501)	12
13	Hickory Healthcare Assoc.	X		Interest income							(861)	13
14	TOTAL Non-Facility Related						$	$ 58,277			$ (445)	14
15	TOTALS (line 9+line14)						$	$ 981,175			$ 68,755	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3	Due on Insurance		X					58,277				3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 58,277			$	21

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 93,711	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 92,790	2
3. Under or (over) accrual (line 2 minus line 1).		$ (921)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 95,574	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 2,160	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 96,813	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	85,314	8
	1997	85,525	9
	1998	88,633	10
	1999	90,982	11
	2000	92,790	12

2001 Accrual = 92790 x 1.03 = $95,574

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HICKORY NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0032029

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE 847-236-1111 FAX #: 847-236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-02-420-007	Long term care property	$ 2,364.24	$ 2,364.24
2.	23-02-420-015	Long term care property	$ 4,468.85	$ 4,468.85
3.	23-01-302-021	Long term care property	$ 6,543.78	$ 6,543.78
4.	23-02-420-016	Long term care property	$ 39,698.23	$ 39,698.23
5.	23-02-420-008	Long term care property	$ 39,715.18	$ 39,715.18
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 92,790.28	$ 92,790.28

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,200 B. General Construction Type: Exterior Brick Frame Brick Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 1,275
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	16,200	1990	$ 74,000	1
2					2
3	TOTALS	16,200		$ 74,000	3

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1990	$ 1,115,000	$ 35,397	35	$ 55,750	$ 20,353	$ 536,273	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	22,801		20	1,140	1,140	13,294	9
10	Various			1988	50,319		20	2,516	2,516	28,118	10
11	Various			1989	7,409		20	370	370	3,660	11
12	Various			1990	38,661		20	1,934	(1,934)	19,439	12
13	Various			1991	6,422		20	321	321	2,948	13
14	Various			1993	30,582		20	1,530	1,530	11,693	14
15	Various			1994	13,592		20	680	680	4,785	15
16	Various			1995	102,781		20	5,139	5,139	31,952	16
17	Various			1996	139,610		20	6,980	6,980	39,523	17
18	Various			1997	54,749		20	2,739	2,739	12,318	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
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27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		3,442	47		291	244	1,332	68
69	Financial Statement Depreciation			29,886			(29,886)		69
70	TOTAL (lines 4 thru 69)		$ 1,585,368	$ 65,330		$ 79,390	$ 10,192	$ 705,335	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,585,368	$ 65,330		$ 79,390	$ 14,060	$ 705,335	1
2	MASONRY	1998	30,700		20	1,535	1,535	5,756	2
3	REPLACE BRICK	1998	3,200		20	160	160	520	3
4	MASONRY	1998	3,700		20	185	185	601	4
5	WATER HEATER	1998	1,062		20	53	53	212	5
6	PIPING	1998	1,200		20	60	60	235	6
7	HEATER	1998	3,134		20	157	157	615	7
8	FLOOR TILING	1998	1,281		20	64	64	251	8
9	CARPET	1998	1,757		20	88	88	345	9
10	CARPET	1998	503		20	25	25	96	10
11	FLOORING	1998	1,728		20	86	86	330	11
12	DRAIN PIPE	1998	2,700		20	135	135	461	12
13	GREASE TRAP	1998	767		20	38	38	127	13
14	AWNINGS	1998	675		20	34	34	111	14
15	DIFFUSER	1998	540		20	27	27	86	15
16	GREASE TRAP	1998	575		20	29	29	89	16
17	SEWER PIPE	1999	650		20	33	33	94	17
18	ELECTRICAL REPAIRS	1999	1,100		20	55	55	160	18
19	SEWER	1999	4,300		20	215	215	466	19
20	REFURBISH ROOMS	1999	1,725		20	86	86	237	20
21	PLUMBING	1999	547		20	27	27	63	21
22	DUMPSTER	1999	1,920		20	96	96	216	22
23	PATIO	1999	1,050		20	53	53	119	23
24	ALUMI-COAT	1999	2,421		20	121	121	272	24
25	CABINETS/COUNTERS	1999	3,303		20	165	165	468	25
26	ALUMI-COAT	1999	1,863		20	93	93	209	26
27	FIRE ALARM REPAIR	2000	569		20	28	28	28	27
28	GAS LINE REPAIR	2000	1,070		20	54	54	54	28
29	GAS LINE REPAIR	2000	1,170		20	59	59	59	29
30	GLASS/DOOR REPAIR	2000	1,562		20	78	78	78	30
31	ELECTRICAL WORK	2000	2,520		20	126	126	126	31
32	SCHEMATIC DESIGN	2001	5,835		20	268	268	268	32
33	LIGHTS	2001	1,306		20	65	65	65	33
34	TOTAL (lines 1 thru 33)		$ 1,671,801	$ 65,330		$ 83,688	$ 18,358	$ 718,152	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,671,801	$ 65,330		$ 83,688	$ 18,358	$ 718,152	1
2	WIRING	2001	5,775		20	289	289	289	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,677,576	$ 65,330		$ 83,977	$ 18,647	$ 718,441	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,677,576	$ 65,330		$ 83,977	$ 18,647	$ 718,441	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,677,576	$ 65,330		$ 83,977	$ 18,647	$ 718,441	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,677,576	$ 65,330		$ 83,977	$ 18,647	$ 718,441	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,677,576	$ 65,330		$ 83,977	$ 18,647	$ 718,441	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 1,677,576	$ 65,330		$ 83,977	$ 18,647	$ 718,441	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,677,576	$ 65,330		$ 83,977	$ 18,647	$ 718,441	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,677,576	$ 65,330		$ 83,977	$ 18,647	$ 718,441	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,677,576	$ 65,330		$ 83,977	$ 18,647	$ 718,441	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 1,677,576	$ 65,330		$ 83,977	$ 18,647	$ 718,441	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,677,576	$ 65,330		$ 83,977	$ 18,647	$ 718,441	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 1,677,576	$ 65,330		$ 83,977	$ 18,647	$ 718,441	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,677,576	$ 65,330		$ 83,977	$ 18,647	$ 718,441	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from Staycare			1992	2,121	47	20	106	59	1,041	9
10	Allocated from Staycare			2000	1,321		20	185	185	291	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,442	$ 47		$ 291	$ 244	$ 1,332	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 113,495	$	$ 10,611	$ 10,611	10	$ 50,321	71
72	Current Year Purchases	13,114		442	442	10	442	72
73	Fully Depreciated Assets	197,306				10	197,306	73
74								74
75	TOTALS	$ 323,915	$	$ 11,053	$ 11,053		$ 248,069	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,075,491	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 65,330	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 95,030	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 29,700	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 966,510	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from Staycare				5,429			5
6								6
7	TOTAL				$ 5,429 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 3,579 Description: Allocation from Staycare $3343, $236 water cooler rental
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 26,133	$		$ 26,133	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			161			161	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			27,046			27,046	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				24,404		24,404	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						870		870	13
14	TOTAL			$		$ 53,340	$ 25,274		$ 78,614	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 103,232	$ 142,886	1
2	Cash-Patient Deposits	15,191	15,191	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	663,941	663,941	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,910	78,910	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		14,039	8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 861,274	$ 914,967	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		74,000	13
14	Buildings, at Historical Cost		1,115,000	14
15	Leasehold Improvements, at Historical Cost	477,449	477,449	15
16	Equipment, at Historical Cost	180,564	291,564	16
17	Accumulated Depreciation (book methods)	(270,977)	(775,779)	17
18	Deferred Charges		12,745	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(3,825)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 387,036	$ 1,191,154	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,248,310	$ 2,106,121	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 51,830	$ 51,830	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,191	15,191	28
29	Short-Term Notes Payable	58,277	58,277	29
30	Accrued Salaries Payable	9,811	9,811	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,128	1,128	31
32	Accrued Real Estate Taxes(Sch.IX-B)	95,574	95,574	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,025	3,025	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	223,490	11,812	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 458,326	$ 246,648	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		922,898	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 922,898	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 458,326	$ 1,169,546	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 789,984	$ 936,575	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,248,310	$ 2,106,121	48

*(See instructions.)

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 738,444	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 738,444	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	199,540	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(148,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 51,540	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 789,984	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,438,933	1
2	Discounts and Allowances for all Levels	(205,578)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,233,355	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	214,245	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 214,245	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,262	19
20	Radiology and X-Ray		20
21	Other Medical Services	43,685	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 45,947	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,501	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,501	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	6,754	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,754	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,503,802	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	517,663	31
32	Health Care	822,299	32
33	General Administration	536,478	33
	B. Capital Expense		
34	Ownership	308,693	34
	C. Ancillary Expense		
35	Special Cost Centers	78,614	35
36	Provider Participation Fee	40,515	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,304,262	40
41	**Income before Income Taxes (line 30 minus line 40)****	199,540	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 199,540	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	950	982	$ 22,833	$ 23.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,612	4,960	100,785	20.32	3
4	Licensed Practical Nurses	15,139	16,003	287,163	17.94	4
5	Nurse Aides & Orderlies	28,674	29,830	263,133	8.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,177	4,449	39,568	8.89	8
9	Activity Director	2,053	2,205	17,088	7.75	9
10	Activity Assistants	2,030	2,166	12,579	5.81	10
11	Social Service Workers	3,031	3,348	32,013	9.56	11
12	Dietician					12
13	Food Service Supervisor	1,832	2,088	26,959	12.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,725	11,283	76,578	6.79	15
16	Dishwashers					16
17	Maintenance Workers	1,687	1,768	14,108	7.98	17
18	Housekeepers	9,557	10,017	79,944	7.98	18
19	Laundry	3,562	3,794	30,728	8.10	19
20	Administrator	2,104	2,336	59,140	25.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	321	338	4,763	14.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,454	95,567	$ 1,067,382 *	$ 11.17	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	148	$ 5,904	01-03	35
36	Medical Director	Monthly	1,800	09-03	36
37	Medical Records Consultant	Monthly	2,048	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,449	10-03	39
40	Physical Therapy Consultant	82	2,909	10a-03	40
41	Occupational Therapy Consultant	101	3,520	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	90	2,252	11-03	44
45	Social Service Consultant	43	1,095	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	464	$ 20,977		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	464	8,700	10-03	52
53	TOTAL (lines 50 - 52)	464	$ 8,700		53

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Doreen Murphy (1/1/01-11/15/01)	Administrator	0	$ 55,000
Paulette Green (11/19/01-12/31/01)	Administrator	0	4,140
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 59,140

B. Administrative - Other

Description	Amount
Staycare management fees	$ 145,255
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 145,255

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg & Rothblatt	Accounting	$ 20,683
See attached schedule	Legal	3,700
Personnel Planners	Unemployment consultant	789
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 25,172

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,002
Unemployment Compensation Insurance	7,265
FICA Taxes	81,425
Employee Health Insurance	42,066
Employee Meals	21,966
Illinois Municipal Retirement Fund (IMRF)*	
Employee benefits	716
Union pension expense	9,352
Christmas expense	581
401k contribution	883
TOTAL (agree to Schedule V, line 22, col.8)	$ 182,256

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Licenses, permits and fees	1,930
Dues & subscriptions	4,200
Classified advertising	6,036
Promotional advertising	923
Staycare allocation	65
Yellow page advertising	6,891
Less: Public Relations Expense	
Non-allowable advertising	(923)
Yellow page advertising	(6,891)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,231

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	974
Allocation from Staycare	236
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,210

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HICKORY NURSING PAVILION # 0032029 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on LTC $1930**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,182** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **40,515**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,966** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees